QUEENS ROAD MEDICAL PRACTICE

NEW PATIENT APPLICATION FORM (16 years and over)

PLEASE COMPLETE IN CAPITAL LETTERS

Evolution Number: .....

Appointment:.....

SURNAME…… Mr/Mrs/Miss/Ms

MAIDEN NAME…….. MARITAL STATUS Married/Single/Divorced/Widowed

FORENAMES…… DATE OF BIRTH…….

USUALLY KNOWN AS…… HOME TELEPHONE ……

ADDRESS…….. MOBILE TELEPHONE…….

(If you DO NOT want to receive appointment text reminders on your mobile telephone please sign here……)

…… WORK TELEPHONE……..

…… PRIVATE HEALTH INSURER……..

POSTCODE…….. POLICY NUMBER……

EMAIL ADDRESS .....

SCHOOL CURRENTLY ATTENDED (IF ANY)…….

SOCIAL INSURANCE NO…… ETHNIC ORIGIN/LANGUAGE ……

When attending your first consultation please provide a urine specimen. Please ask receptionist for a specimen bottle.

Declaration:

I understand that the Practice has the right to accept or decline this application.

I agree to pay for all treatment given by the Practice. Full details of pricing available from reception or on our website www.egrmp.com

I agree that the Practice may disclose personal details and details of medical records regarding both myself and my dependants to all those involved in providing me/them with healthcare and related services both inside and outside the Practice.

I give my permission to the Practice to request information from my previous doctor and I agree to meet reasonable charges relating thereto.

SIGNED…… DATE……..

Please supply photographic proof of identity (passport/drivers' licence/student card/work ID card etc)

ARE YOU A "CARER"……YES / NO

DO YOU HAVE A "CARER"……YES/NO – if yes – NAME:……..

NEXT OF KIN

NAME…….. RELATIONSHIP……

ADDRESS…….. TELEPHONE ……

…… MOBILE NUMBER…….

……. WORK NUMBER ……..

NAMES OF CHILDREN:

SURNAME…… FORENAME(S)……..DOB……..

SURNAME…… FORENAME(S)……..DOB……..

SURNAME…… FORENAME(S)……..DOB…….

EMPLOYER

OCCUPATION……

EMPLOYER'S NAME……TELEPHONE ……

ADDRESS……..

PREVIOUS DOCTOR

NAME…….. TELEPHONE ……

ADDRESS……

WHICH DOCTOR WOULD YOU LIKE TO BE REGISTERED WITH ?……

IF YOU HAVE MOVED TO GUERNSEY IN THE LAST YEAR PLEASE STATE:

DATE OF ARRIVAL…… INTENDED LENGTH OF STAY……

PREVIOUS ADDRESS……

……

HOW DID YOU HEAR ABOUT OUR PRACTICE? (*please delete as appropriate***)**

PRACTICE WEBSITE / 'BEST OF GUERNSEY' WEBSITE / PERSONAL RECOMMENDATION / OTHER

Ethnicity

White	Asian/Asian British	Black/Black British	Chinese/Other Ethnic group
British □	Indian □	African □	
Irish □	Pakistani □	Caribbean □	Chinese □
Other □	Bangladeshi □	Mixed White/Black African □	Other □
	Mixed White/Asian □	Mixed White/Caribbean □	

Eastern European Polish □ Latvian □ Other □

Portuguese/Madeiran □

Country of Birth: _____

Main Language Spoken: _____

Religion……..

Have you ever been registered here before? **Yes** / **No**

Have you seen a doctor within the last 12 months? If so, please give details:

Do you have or ever had any of the following?

	Yes	**No**		**Yes**	**No**
1.Asthma			10.Epilepsy		
2.Other breathing problems			11.Bowel or stomach problems		
3.High blood pressure			12.Kidney or bladder problems		
4.Heart disease			13.Skin problems		
5.Faints or blackouts			14.Depression or mental health problems		
6.Deep vein thrombosis (blood clot)			15.Any operation/surgical procedure		
7.Diabetes			16.Visual or hearing impairment		
8.Allergy to medication/food/other			17.Blood disorder		
9.Sexually transmitted infection			18.Hepatitis or liver disease		

If you have answered Yes to any of the above, please give details with dates (if applicable)

FEMALE PATIENTS ONLY

Please give date **&** result of last smear test _____
Have you ever been pregnant? If so, how many times? _____
Were your deliveries normal or assisted?_____
Any history of gynaecological problems or infections? _____
Date of last mammogram (if applicable) _____
Please give details of any contraception (if applicable)_____

FOR ALL PATIENTS

Do you smoke? Yes / No
If yes, please state – cigarettes/cigars/roll-ups/pipe. How many/much per day? _____

Are you an ex-smoker? Yes/No
If yes, when did you give up? _____

How much alcohol do you drink per week? _____units
(a unit =1 small glass of wine / 1 single measure of spirit / half pint normal strength beer/lager)

Exercise	**Times**	
How many times do you exercise each week?	None	
	Once a week	
	Twice a week	
	Three times + a week	
How many hours do you exercise each week?	Zero	
	Less than 1 hour	
	1 to 3 hours	
	More than 3 hours	

FAMILY HISTORY – FOR ALL PATIENTS

Do your parents, brothers or sisters have any of the following? (**M**-mother, **F**-father, **S**–sister, **B-**brother)

	Yes	**Who/age**		**Yes**	**Who/age**
Diabetes			Heart attack		
Asthma			Bowel cancer		
High blood pressure			Breast cancer		
Stroke/CVA/TIA			Ovarian cancer		
Epilepsy			Family history not known – adopted		

Please enter details of any immunisation/vaccination that you know you have received:

Name of immunisation/vaccination	Date given	Where given	Any known side effects

Guidelines for Childhood Vaccination Schedule – full details of children's immunisation are available in the patient held "green book":

2 months:	Diphtheria, Tetanus, Pertussis, Polio, HIB, Pneumococcal
3 months:	Diphtheria, Tetanus, Pertussis, Polio, HIB, Meningitis C
4 months:	Diphtheria, Tetanus, Pertussis, Polio, HIB, Meningitis C, Pneumococcal
12 months:	HIB, Meningitis C,
13 months:	Measles, Mumps, Rubella (MMR), Pneumococcal
3yrs 4 months to 5 years:	Diphtheria, Tetanus, Pertussis, Polio, Measles, Mumps, Rubella (MMR)
13-14 years: (females only)	HPV vaccine (3 doses)
13 to 18 years:	Diphtheria, Tetanus, Polio

Are you taking any 'over-the-counter' medication? If so, please give details:

Are you taking any medication prescribed by a doctor/specialist? If so, please give name & dose:

Please enter any other information concerning your health that you feel may be useful to your doctor.

Practice use only:

Original details taken by…… Appointment made……

Account number……

Doctor seen…… Checked in by……

Paid/Bill Photographic ID checked by…….. Date……..

Letter PMH/Accept Accepted by Doctor…… Date……